able." Almost two fifths (39.7%) of all physicians admitted to feeling sometimes or often uncomfortable treating homosexual patients.

The preliminary results of this survey of the San Diego County Medical Society indicate a substantial prevalence of negative attitudes toward homosexual persons as both colleagues and as patients. We wonder how the recent publicity about AIDS has affected these attitudes.

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Thromboembolic Complications of Knee Arthroscopy

To the Editor: Although arthroscopy of the knee is considered to be a relatively safe procedure, reported complications have included minor articular cartilage damage, saphenous nerve injury, hemarthrosis, subcutaneous emphysema, deep vein thrombosis and pulmonary embolism. Of these, thromboembolism presents the greatest potential harm to patients. The incidence of clinical deep vein thrombosis following arthroscopy of the knee is reported to be as high as 1.6%, but subclinical thromboembolism may be much greater.[1]

Reports of Cases

We report three recent cases of thromboembolic complications following arthroscopy of the knee. The first patient was a 33-year-old man in whom pain in the left calf, swelling and pleuritic chest pain developed three days after meniscectomy. A radionuclide ventilation-perfusion scan was positive for pulmonary embolism. A 16-year-old man noted pain in his left calf four days after arthromeniscectomy, and contrast venography showed obstruction of a deep popliteal vein. And, finally, a 28-year-old man required evaluation of calf paresthesia and pain ten days following arthroscopy of the same knee. Again, a contrast venogram showed popliteal deep venous thrombosis. All patients responded quickly to anticoagulation.

It is important for physicians to realize that this potentially life-threatening complication of knee arthroscopy, deep vein thrombosis, occurs with some frequency and should be suspected promptly when calf pain occurs after the procedure.

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Individualism Versus Collectivism

To the Editor: From the manner in which you framed your understanding of how we got where we are (editorial: "America's Ways of Doing Things"[1]), I have some difficulty fitting historical events into your framework. From our long period of individualism with a free market, limited government, private responsibility and traditional social and moral values, we changed to the current collectivism with its all powerful central government and a planned economy, variously known as socialism, and a welfare state. My intent is to provide a few observations on what trends, what currents of ideologic dissemination, underlay this change. It took many decades of masterful activity by intellectuals advancing reforms to alter our traditional concepts of the proper role of government in our social order.

Following on the heels of Chancellor Bismarck's reforms in Germany and almost coincidental with Fabian socialism in England, the 1890's in the United States were productive in books on utopian thought. Following one such book—Edward Bellamy's *Looking Backward* (published in 1888 and still in print)—162 "nationalist" clubs were formed in 27 states in 1890 to discuss what was (but was denied as being) "obviously (a) socialist system." Bellamy's followers were "college professors, editors, artists and authors."[2]

The real intellectual impetus, however, occurred in 1905 with the organization of the Intercollegiate Society of Socialists. Its aims were to acquaint collegians not only with collectivist doctrines but also to influence college-bred men and women who were assuming a growing role in government. In 1921 the society was reorganized into the Student League for Industrial Democracy with the avowed purpose of "education for a new social order based on production for use and not for profit." By the 1930's, there were 125 institutions of higher learning with chapters of the organization. The graduates exerted their influence in the classroom, from the pulpit, in labor circles, media and politics. Collectivism became the dominant social creed in the universities.

(Parenthetically, much of this ideology reached the councils of the American Medical Association between 1916 and 1920. See Morris Fishbein's history of the AMA for details on the reversal [1920] of its approval of state medicine.[3] This, of course, did not occur overnight. As far back as March 25, 1893, a *JAMA* article endorsed state medicine.[4])

The majority of the key government positions were filled by President Franklin Roosevelt from the ranks of universities where the new order was taught. It is to their influence that collectivism can be attributed. To be sure, the citizenry did not vote for such a change or clamor for it; the Democratic platform of 1932 was a guide to what was intended. The platform was a complete antithesis to what followed. (It was amusing to hear Senator Goldwater's remarks about the similarities of the 1932 platform to his of 1964.) After Roosevelt's reelection in 1936, it became obvious that the "creeping

collectivism" initiated by President Hoover after the 1929 crash (but almost totally impotent from lack of political support) became a galloping force in American politics.

So, you see, long before the scientific era of medicine with its "complexities," from which you (correctly) date the government's active intrusion into medicine, there was a long period of indoctrination—from idea to law. The key to all freedom is, of course, economic freedom. And you rightly state that we do not have it in the market component of medical care. The economic underpinning of medical professionalism is being slowly eroded. There is much antibusiness indoctrination currently. But business has been fighting back, like we in medicine have for so many decades. It is also our battle.

Herbert S. Richey once asked: "Can it be that there is one thing capitalism cannot do? And that thing is, survive its own success?"[5] Isn't that what is happening to American medicine?

And the lesson for us? It is an old one, an antidote, often expressed as the "art of medicine." But what escapes our recognition is that person-to-person care is a symbolic expression of the ideologic clash between individualism and collectivism: It is absent in state medicine. It is our means of survival through the power of the people.

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Other Treatments for Herpes Zoster Neuralgia

TO THE EDITOR: The review of clinical aspects of herpes zoster by R. B. Glaser in the November 1983 issue[1] was most comprehensive, but omitted to mention a highly effective therapy for one of the more serious complications of herpes zoster, namely postherpes zoster neuralgia. Prednisone and several other "possibly effective" internal medications were listed, but vitamin E, a simple, nontoxic agent was not included.

In 1973[2] we reported a series of 13 patients who had suffered moderate to severe pain over a period of months or years following an attack of herpes zoster, who responded to large doses of vitamin E. Of the 13 patients, 11 had had moderate to severe pain for more than six month; of these, 7 had had the pain for more than a year, 1 for 13 years and 1 for 19 years. Severity of the pain was estimated by the amounts of analgesics and sedatives required to control the pain. Nine patients experienced complete or almost complete relief, two were moderately improved and two thought they were slightly improved. Two of those who had complete or almost complete relief from pain were the two patients who had had neuralgia for 13 and 19 years respectively.

Vitamin E in the form of d, alpha-tocopherol acetate was administered in doses of 400 IU two to four times a day before meals. Inorganic iron, such as contained in reenforced white bread and many cereals, was avoided because it tends to combine with and inactivate vitamin E. Female hormones, including those in birth control pills, also inactivate vitamin E. Since vitamin E improves the tone of the heart muscle and improves glycogen storage, patients with hypertension or damaged hearts and those with diabetes receiving insulin should be started on much smaller doses, such as 100 IU once a day, which can be increased by monitoring the blood pressure or the serum glucose concentration.

The mode of action by which vitamin E relieves post-zoster pain is not known, but the high degree of effectiveness, the absence of undesirable side effects, and the present lack of adequate treatment would justify a wider use of this simple therapy.

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TO THE EDITOR: It is unfortunate that there is not a better exchange of information between various medical specialties. In Dr Richard Glaser's otherwise excellent article on herpes zoster[1] he fails to mention a modality of treatment that provides immediate dramatic relief to patients, prevents postherpetic neuralgia and is safer than high doses of corticosteroids. I am referring to the use of intralesional injections of triamcinolone into the affected dermatome.[2]

The treatment should be begun as early as possible and the patient should have the injection every 48 to 96 hours for the first week. The dose is usually 15 to 40 ml with a concentration of 4 to 5 mg of triamcinolone acetonide (Kenalog) per ml of either saline or xylocaine. Dermatologists have used this for years and those other physicians who have seen the results either learn to do it themselves or readily refer their patients. In many cases the results can be dramatic, and after using this on hundreds of patients over 15 years, I firmly believe it is a disservice to our patients not to get them started on this program as early as possible.

Also to be mentioned is acyclovir given intravenously in those cases of necrotic zoster. The anesthesiologists use sympathetic blocks with success.

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